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In the Supreme Court of the United States

OCTOBER TERM 1983

SOUTHEAST VOLUSIA HOSPITAL DISTRICT, ET AL.,
Appellants

vs.

FLORIDA PATIENT'S COMPENSATION FUND, ET AL.,
Appellees.

ON APPEAL FROM A JUDGMENT OF THE FLORIDA SUPREME COURT

Alternative Motions to Dismiss Appeal or to Affirm Judgment Appealed

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vs.

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ON APPEAL FROM A JUDGMENT OF
THE FLORIDA SUPREME COURT

ALTERNATIVE MOTIONS TO DISMISS APPEAL OR TO AFFIRM JUDGMENT APPEALED

Appellees, the FLORIDA PATIENT'S COMPENSATION FUND and the STATE OF FLORIDA, DEPARTMENT OF INSURANCE, hereby move to dismiss the instant appeal from the judgment of the

Florida Supreme Court, reported at 438 So.2d 815 (Fla. 1983) as not presenting a substantial federal question, or in the alternative, to summarily affirm the judgment of the Florida Supreme Court on the ground that the questions on which the decision of the cause depend are so insubstantial as not to need further argument. These motions are made in one combined pleading, pursuant to Rule 16 of this Court's Rules.

INTRODUCTION

Appellants are hospital members of the Florida Patient's Compensation Fund ("Fund"), appellee, who are attempting to use "substantive due process" and equal protection arguments as a defense to their liability for deficit assessments found necessary for the Fund's solvency by the Florida Department of Insurance and the Florida courts. It is undisputed that the Fund needs the assessments to make payments on judgments or settlements of medical malpractice claims. Since the Fund only covers the portion of claims over $100,000, it follows the Fund only compensates seriously injured medical malpractice plaintiffs.

Appellant hospitals have fought the assessments for which they are contractually and statutorilly liable since 1981, mostly on a melange of state statutory interpretation and state constitutional law theories. Because the Florida courts occasionally apply an equal protection/due process analysis more searching than that applied in the federal courts, *e.g.*, *State v. Lee*, 356 So.2d 276 (Fla. 1978), the hospitals placed primary reliance on the *Florida* equal protection and due process clauses and cited Florida cases. Nonetheless, in their briefs to the Florida courts, the Hospitals did raise—in passing—

the parallel federal constitutional guarantees, citing one or two federal cases. These half-hearted arguments, like all the hospitals' other arguments, were rejected.

The hospitals concede that the issue is whether there was a rational basis for the legislature to decide as it did. The hospitals however, apply the "rational basis" test in a decidedly unfamiliar fashion. No factual evidence was advanced by the hospitals to show that the legislative scheme was irrational. The actions of the Florida legislature, on their face and in light of the statutory purposes set out in the preamble and other plausible purposes inferable from the statute, were plainly reasonable. For these reasons, this Court should summarily dispose of the Hospitals' specious challenge to the Fund statute's assessment provisions and grant one of these alternative Motions to Dismiss for Want of a Substantial Federal Question or to Summarily Affirm.

Nature of the Issues

The Florida Patient's Compensation Fund ("Fund") is a non-profit entity which exists to provide medical malpractice protection for Florida health care providers (hospitals and physicians) who choose to join it. The Florida Patient's Compensation Fund is one of a number of the Florida legislature's responses to the Medical Malpractice Crisis of 1975, when "there was an imminent danger that a drastic curtailment in the availability of health care services would occur in this state." *Carter v. Sparkman*, 335 So.2d 802, 805 (Fla. 1976) (holding another aspect of legislative response constitutional, and discussing legislative preamble). This Court must view the constitutionality of the statute at issue in

light of the Florida legislature's explicit findings of a crisis in the preamble to Ch. 75-9, Laws of Florida. *Quoted, Carter, supra*, 335 So.2d at 805-06.

Physicians and hospitals voluntarily choose whether or not to join the Fund after fees are set for the start of a Fund year, relying on the statutory terms of Fund membership, Fla. Stat. §768.54.

One of the terms of Fund membership is that if claims by medical malpractice plaintiffs against the Fund* exceed the fees paid by members for a particular Fund year,** (plus the interest the fees have earned), then the members will be liable for a deficit "assessment." This is the means that the Fund is kept solvent. It is undisputed that if these assessments are not paid, the Fund will be insolvent and unable to pay the judgments or settlements of medical malpractice plaintiffs against Fund members.

The appellant Hospitals do not contest the validity of the Florida Patient's Compensation Fund *per se*. Indeed, they have admitted that the concept of a state-regulated Fund of health care providers providing each other medical malpractice protection, although it might be novel or in some ways experimental, is well within the Legislature's power. Nor do the Hospitals complain that assessments are used to finance the Fund or argue

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*Fla. Stat. §768.54 provides that the Fund may be joined as a party defendant in lawsuits by medical malpractice plaintiffs against Fund members.

**Under the statutes, members join separately for different years, which are separate accounting units.

that an assessment is not properly due now. The hospitals are left to attack only one sentence of the fund statute, which concerns the allocation of assessments among Fund members. The statute, §768.54(3)(c), as amended in 1976, by Chapter 76-260, Laws of Florida, states that if a deficit assessment is necessary "to obtain the money necessary to meet all claims" for a particular Fund (fiscal) year, the assessment will be spread among Fund members on an actuarial basis, except that

> In no case shall any [deficit] assessment for a particular year against any health care provider other than [a hospital] exceed an amount equal to 2 times the fees originally paid by such health care provider for participation in the fund for the fund year giving rise to such [deficit] assessment.

The Hospitals would like to remove the sentence just quoted from the Fund statute. If physician assessments were not limited, hospitals' assessments would be lower. This Court, however, will not use the Equal Protection or Due Process clauses to release the Hospitals from their contracts, and so their appeal should be handled summarily.

I.

THE VOLUNTARINESS OF FUND MEMBERSHIP IS A "COMPLETE ANSWER" TO THE HOSPITALS' CONSTITUTIONAL ARGUMENTS

The key fact about Florida health care providers' membership in the Florida Patient's Compensation Fund is that it is voluntary. It is true that Florida hospitals

are compelled to be financially responsible, while Florida physicians are not. Nonetheless, Fla. Stat. §768.54(2)(c) (A. 78 of Hospitals' Appendix) at the relevant time allowed the Hospitals to meet this requirement in several ways: posting bond of not more than $2.5 million; placing not more than $2.5 million in escrow; or obtaining private insurance or self-insurance of no more than $2.5 million. It is undisputed fact, as found by the independent hearing officer below:

> The Fund is a private not-for-profit organization, *participation in which is totally voluntary for its member-health care providers.* Insofar as [the Hospitals] are concerned, membership in the Fund is but one of several options available to provide legally required evidence of financial responsibility in order to obtain licensure as a hospital in Florida. *In fact, of the approximately 260 hospitals in Florida, only 125 satisfy their financial responsibility requirement via membership in the Fund.*
>
> (A. 58 of Hospital's Appendix; Emphasis added).

The hospitals have argued that because they are required to be financially responsible, their membership in the Fund is not voluntary.* In view of the fact that *only half of Florida hospitals joined the Fund for the relevant year,* it is obvious that Fund membership is voluntary.

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*The intermediate Florida appellate court seemed to agree with this argument, but the Supreme Court rejected it in holding the Fund satisfied due process because it "provide[s] medical malpractice protection for Florida health care providers *under terms accepted by the participants*". (A. 17 of Hospitals' appendix.)

This circumstance cuts off any need of this Court to examine the Hospitals' arguments. This is not a constitutional law case, but a contracts case. Private parties every day enter into contracts which might be unconstitutional if the state required them to be performed. Even a burdensome contract voluntarily entered into with a private entity created by statute, without more, raises no constitutional issue. Because the state courts have resolved the state law issue of whether the Department of Insurance has correctly interpreted the Hospitals' contractual/statutory obligation, there is no remaining issue for this Court. The statute at the time the Hospital joined provided warning that assessments for physicians would be limited to the amount of fees originally paid, while hospitals' assessments would not be so limited. The contract documents which each Hospital executed before it agreed to join the Fund plainly made the same point (A.3). These documents were in the record below and are ~~attached in the Appendix hereto (A.1-A.5).~~ Lodged

Precedent from this Court establishes that the Hospitals' decision to join the Fund *while the cap on physician assessments of which they complain was on the books* creates an estoppel against the Hospitals to challenge the Fund statute.* It is undisputed the Hospitals have received benefits from the Fund—many of their claims have been paid by the Fund for the Fund years in question. Moreover, the Hospitals are not offering to repay these payments or even turning down the defense

*Their voluntary decision makes it impossible, in our view, for them to prevail on the merits as well. If the statute were as irrational as they say, surely they would not have joined the Fund.

of pending suits in these Fund years by the Fund. The Hospitals have received and still are receiving benefits at the expense of the Fund. Therefore, they are estopped from claiming their part of the contract is illegal. A case from this Court that is closely on point is *Booth Fisheries Co. v. Industrial Commission of the State of Wisconsin*, 271 U.S. 208 (1926). In that case an employer challenged an award under Wisconsin's Workmen's Compensation scheme, after the employer had voluntarily elected to participate in the scheme. This Court summarily rejected its arguments:

> *A complete answer to this claim is found in the elective or voluntary character of the Wisconsin Compensation Act.* That act provides that every employer who has elected to do so shall become subject to the act . . . In view of such an opportunity for choice, the employer who elects to accept the law may not complain [of the specifics of the statute he elected to follow.]
>
> More than this, the employer in this case having elected to accept the provisions of the law, and such benefits and immunities as it gives, may not escape its burdens by asserting that it is unconstitutional. *The election is a waiver and estops such complaint.*

Id. at 210-11. (Emphasis added.)

Accord: Fahey v. Mallonee, 332 U.S. 245, 255-56 (1947); *Ashwander v. Tennessee Valley Authority*, 297 U.S. 288, 348 (1936) (Brandeis, J., concurring) ("The Court

will not pass upon the constitutionality of a statute at the instance of one who has availed himself of its benefits"). Because the undisputed voluntariness of the Hospitals' action is also a "complete answer" to all their objections to this Court, that circumstance is enough to mandate the dismissal of the appeal or summary affirmance of the judgment of the Florida Supreme Court.

Aside from constitutional estoppel principles, we note the Hospitals are trying to walk away from their contracts. Yet they have *at no point* done what is essential for rescission, that is, offer to place the other contractual parties in the *status quo ante*. Without the assessments, it is impossible to provide alternative insurance to other Fund members, or alternative means to pay victims of medical malpractice who are entitled to be compensated by the Fund. The Hospitals simply ignore these interests.

The Hospitals purport to rely on the principle that "legal burdens should bear some relationship to individual responsibility or wrongdoing". Jurisdictional Statement at 16-17. The illegitimacy cases quoted by the Hospitals are obviously irrelevant. The Hospitals are "responsible" for these assessments, not because of tort liability, to be sure, but because of the terms of their contract with the Fund. It is this contractual responsibility which is controlling here.

The Hospitals, in their factual statement, emphasize that "physicians" as a class are paying less to the Fund than the amount of claims filed against physicians. This so-called "subsidy" of physicians by Hospitals is the sole basis of the Hospitals' constitutional challenges. The Hospitals are missing the point. As they argue,

the Fund is "a kind of group self-insurance". Jurisdictional Statement at 6. Since there is an element of group self-insurance in the Fund, participants are liable for *each other's* claims under the terms of the agreement. The Fund provides "occurrence basis" coverage, so that (for example) those causing malpractice claims by treatment between July 1, 1977 and June 30, 1978 (the 1978 Fund year) will be "subsidized" by those Fund members who have no claims brought against them arising out of that time period. Can those who have no claims against them get a reimbursement of their fees, or avoid the liability for assessments set out in their contract? Even though these individuals have been careful, have been excellent risk managers, and have avoided all wrongdoing, the answer must be "no". The answer to the hypothetical complaint of the claimless Fund member is the same as to the Hospitals': "You don't argue that your contract was improperly interpreted, and so you are liable under the terms of your agreement." The "subsidy" inherent in any voluntary program of group self-insurance raises no constitutional issue. For this reason, this appeal should receive summary disposition from this Court.

The Facts of Fee-Setting In These Fund Years Do Not Help The Hospitals

The Hospitals spend much effort in describing how the Florida Patient's Compensation Fund came to need large assessments to pay the claims against it. These facts, however incompletely stated by the Hospitals, cannot aid the Hospitals who do not claim: (1) that they were not aware of the amount of fees when they joined the Fund (they were aware of the fees charged all Fund members); or (2) that the fees were improperly set in

violation of any federal constitutional norm (the Hospitals never even argued this below). In fact, the Insurance Commissioner made a good faith effort to set fees at an actuarially sound level but—disregarding the argument of the Fund and ruling with the very Hospitals who now complain—made an *erroneous prediction* on the level of future medical malpractice claims in Florida. The base fees for prior years had proved adequate, as is shown by the fact that these assessments were the first ever needed by the Fund. The major reason for the change that can be identified from this record is that medical mediation panels, *see Carter v. Sparkman*, 335 So.2d 802 (Fla. 1976), widely regarded as a significant barrier to medical malpractice plaintiffs' pursuit of their claims, were declared unconstitutional by the Florida Supreme Court in *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980).

The Florida statute was worded in such a way that if the Insurance Commissioner, in his discretion, did not find higher "additional" fees necessary, the "base fees" set out in the statute, which were mandated for the 1975-76 Fund year, would go into effect. For the 1977-78 Fund year, these base fees went into effect with no one seeing any reason to raise the fees, which had proven satisfactory under prior (sparse) claims experience. For the 1978-79 Fund year, the Fund management itself, acting on the advice of an actuarial report, sought higher fees than base fees. Upon the Fund's petition to the Insurance Commissioner, a hearing was held and health care provider representatives—both physicians and hospitals—argued that higher fees were not necessary, in view of medical mediation panels and the still low claims experience of the Fund. *None of the hospitals now saying that higher fees should have been*

set argued that at the time. The hospitals therefore share the blame for the inaccuracy of the Insurance Commissioner's predictions. The Florida courts have held that because assessments are now required to meet claims, the historical reasons why an assessment is necessary need not be examined under state law. Should this Court examine them, the Hospitals cannot profit by their own error in opposing the higher fees sought by the Fund.

II.

THE HOSPITALS' EQUAL PROTECTION ARGUMENTS DO NOT WARRANT FULL CONSIDERATION BY THIS COURT

The Hospitals agree that the cap on physicians' assessments is a social or economic regulation which is governed by the extremely deferential "rational basis" test. Indeed, leaving aside *Zobel v. Williams*, 457 U.S. 55 (1982), whose "right to travel" implications make it clearly inapposite,* the only case in recent memory overturning an economic statute on equal protection grounds, *Morey v. Doud*, 354 U.S. 457 (1957), was overruled in *City of New Orleans v. Dukes*, 427 U.S. 297 (1976). The facts of this case certainly do not warrant reexamination of this court's consistent and long-standing unwillingness to second-guess plainly rational legislative economic judgments.

*The key to the *Zobel* case is the court's worry that if the classification in question (length of residence in a state) were valid, the state could condition all State benefits on that basis.

Equal Protection Standards

The well settled principles of the "rational basis" equal protection test can be briefly summarized:

> In the area of economics and social welfare, a state does not violate the Equal Protection Clause . . . merely because the classifications made by its laws are imperfect . . . As long as the classificatory scheme chosen by [the legislature] rationally advances a reasonable and identifiable governmental objective, we must disregard the existence of other methods of allocation that we, as individuals, perhaps would have preferred.
>
> *Schweiker v. Wilson*, 450 U.S. 221, 234-35 (1981)
>
> "When the classification in such a law [subject to review under the rational basis test] is called in question, if any state of facts reasonably can be conceived that would sustain it, the existence of that state of facts at the time that the law was enacted must be assumed" . . . [If there are] plausible reasons for [the legislative] action, . . . it is, of course, "constitutionally irrelevant whether this reasoning in fact underlay the legislative decision.'
>
> *United States Railroad Retirement Board v. Fritz*, 449 U.S. 166, 174 (1980)
>
> Although parties challenging legislation under the Equal Protection Clause may introduce evidence supporting their claim that it is

> irrational, [citation omitted], they cannot prevail so long as "it is evident from all the considerations presented to [the legislature], and those of which we may take judicial notice, that the question is at least debatable."
>
> *State of Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456, 464 (1981)

As well-worn as these principles are, their application to this case would create no new law nor illuminate any uncertain areas. There is simply no reason for this Court to further consider this case.

The hospitals do manage to cite a handful of cases in their Jurisdictional Statement. Most of the cases involve improper or disapproved legislative purposes, such as discrimination against illegitimate children, non-residents, or aliens. The Hospitals at no point question the validity of the legislative goals in this case of reducing health cost care in Florida, and indeed approve this purpose at pages 19 and 22 of their Jurisdictional Statement. Therefore, the cases cited by the Hospitals are far off-point.

Purposes of the Physician Assessment Cap

The physician assessment cap was added by Chapter 76-260, Laws of Florida, as the Florida intermediate appellate court realized, "to offer greater protection for physicians," as a means of lowering health care costs. *Southeast Volusia Hosp. v. State, Dept of Ins.*,

432 So.2d 592, 595 (Fla. App. 1 Dist. 1983). The statutory preamble states:

> WHEREAS, despite the responsive and responsible actions of the 1975 session of the Legislature, professional liability insurance premiums for Florida *physicians* have continued to rise and, according to the best available projections, will continue to rise and, according to the best available projections, will continue to rise at a dramatic rate, and
>
> WHEREAS, insurance companies across America are continuing to withdraw from the medical professional liability insurance market so that such insurance, even at exorbitant rates, is becoming virtually unavailable in the voluntary private sector, and
>
> WHEREAS, the maximum rates for essential medical specialists such as cardio-vascular *surgeons, neurosurgeons, orthopedic surgeons,* and *anesthesiologists* range from $8,200 in *physician*-owned trusts to $24,000 through the JUA, and
>
> WHEREAS, a certain amount of these premium costs are passed on to the consuming public through higher costs for health care services in addition to the heavy and costly burden of "defensive medicine" as *physicians* are forced to practice with an overabundance of caution to avoid potential litigation, and

WHEREAS, this insurance crisis threatens the quality of health care services in Florida as *physicians* become increasingly wary of high-risk procedures and are forced to downgrade their specialties to obtain relief from oppressive insurance rates, and

WHEREAS, this crisis also poses a dire threat to the continuing availability of health care in our state as new *young physicians* decide to practice elsewhere because they cannot afford high insurance premiums and as *older physicians* choose premature retirement in lieu of a continuing diminution of their assets by spiraling insurance rates, and

WHEREAS, our present tort law/liability insurance system for medical malpractice will eventually break down and costs will continue to rise above acceptable levels, fundamental reforms of said tort law/liability insurance system must be undertaken, and

WHEREAS, the continuing crisis proportions of this compelling social problem demand immediate and dramatic legislative action . . . (Emphasis added. A. 27 of Hospitals' Appendix).

It is apparent that the immediate purposes of the physician cap on assessments are to lower the (1) cost and (2) uncertainty of medical malpractice protection for Florida *physicians*. To encourage physicians to locate or remain in Florida, to discourage costly defensive medicine, and to attempt to control ultimate health care costs to consumers are plainly legitimate state objectives.

The Florida Supreme Court held the statute valid against equal protection objections in language fully consistent with this Court's jurisprudence:

> [The Department of Insurance and the Fund] contend that hospitals and physicians are not similarly situated and we agree. While both may fall under a general classification, health care providers, they clearly are not similarly situated. *Hospitals are corporate entities with larger budgets and much larger numbers of patients over which to spread costs.* There are numerous differences between the two which justify the different treatment of these two groups by the statute.
>
> *Department of Ins. v. Southeast Volusia Hosp. Dist.*, 438 So.2d 815 at 821 (Fla. 1983) (Emphasis added)

The decision of the Florida Supreme Court was correct and fully consistent with the cited principles of this court's constitutional jurisprudence. Indeed, in light of the purposes of the statute, there are at least *five* rational bases for a distinction between hospitals and physicians—all effectively admitted by the Hospitals—any one of which is sufficient to summarily dispose of the constitutional issue over which the Hospitals wish this Court to linger.

A. It was Rational For the Legislature to Believe Hospitals Are Better At Spreading the Costs of Medical Malpractice Premiums to the Health Care Consumer.

The Fund statute provides that assessments of Fund members are the means by which the Fund would be financed. Ultimately the total assessment must be paid by Florida health care consumers, and so how it is distributed to them is a matter of constitutional indifference. The Hospitals admit they have larger budgets. Jurisdictional Statement at 20-21. The legislature was rational in believing that hospitals with these larger budgets could more easily absorb the shock of a large assessment and pass it on to the ultimate Florida health care consumers.

B. It Was Rational For the Legislature to Believe That Minimization of Medical Malpractice Costs and Uncertainty Was More Important For Physicians Than For Hospitals.

The legislature was reasonable in believing that physicians would be more likely to practice wasteful defensive medicine, limit their practice, or even move out of state if their assessment liability were not limited. As the Hospitals admit, Jurisdictional Statement at 21, hospitals are permanent (or nearly permanent) fixtures in their communities and will continue to provide medical care regardless of their assessment liability. Hospitals are already greatly involved with government grants and government-imposed costs. This Court only recently, in *Revere v. Massachusetts General Hospital*, ____ U.S. ____, 77 L.Ed 2d 605, 103 S.Ct. 2979 (1983), noted that

> Many hospitals are subject to federal or state laws that require them to provide care to indigents. Hospitals receiving federal grant money under the Hill-Burton Act, for example, must supply a reasonable amount of free care to indigents. [Citation omitted.] In the Commonwealth of Massachusetts now, any hospital with an emergency room facility must provide emergency services regardless of the patient's ability to pay. [Statutes cited] Refusal to provide treatment would subject the hospital to malpractice liability.
>
> *Id.*, 77 L.Ed. 2d at 611-612.

Just as these regulations raised no federal constitutional question, the assessment allocation scheme Florida has decided to employ for the Fund raises no such issue.

C. It Was Rational For the Legislature to Believe that Physicians Would Not Join the Fund Without A Cap on Assessments.

Under the Florida statutes, hospitals are required to be "financially responsible" either through Fund membership, or some other means. Physicians, on the other hand, are subject to no similar constraint. If the physicians' assessment liability were not carefully limited, therefore, physicians might not join the Fund, instead entering the ranks of Florida physicians who take the risk of foregoing medical malpractice protection. The legislature could rationally have believed that physicians would not have joined the Fund if there were unlimited liability for assessments. This would have thwarted

another key purpose of the Fund statute – as the Fund's title indicates – providing a means of *compensating Florida patients* with medical malpractice claims. The Fund can only compensate, of course, for the actions of its members, and then only if enough Florida health care providers join to make it an actuarially sound risk spreading device. The Legislature could rationally have believed that the cap on physician assessments would encourage more physicians to join the Fund rather than go without medical malpractice protection. This is enough by itself to validate the challenged classification.

D. It Was Rational For the Legislature to Believe Hospitals Are A Proper Focus For Medical Malpractice Prevention.

The Hospitals admit that "if placing the burden of physician malpractice on hospitals is rationally related to the goal of lower medical malpractice insurance cost for health care providers in general, including hospitals and their patients," then the Statute would be constitutional. Jurisdictional Statement at 22-23. This is not a necessity, of course, because Fund membership is voluntary. Even if the legislature had *required* the hospitals to join the Fund, however, the differential assessment scheme could be upheld on the precise basis admitted by the Hospitals. It is the challengers' burden to establish that a classification is irrational. All the evidence in this proceeding supports the rational legislative assumption that placing costs of medical malpractice on hospitals would place it on entities which can reduce malpractice costs. If hospitals are responsible for the bulk of assessments, they have an incentive to lower the incidence of medical malpractice.

It is undisputed that 80% of all malpractice claims originate in hospitals. In-house physicians, concededly under the full control of hospitals, can be used to limit the incidence of malpractice claims in any manner directed by the hospital. Even a staff ("independent contractor") physician cannot practice in a hospital without the hospital's approval. The Insurance Commissioner noted below that evidence was presented that "hospitals could revoke the staff privileges of physicians not complying with risk management programs implemented by the hospitals." Final Order at 11. (Hospitals' appendix at A40). Even if, as the Hospitals have argued, it is difficult to deny hospital privileges to staff doctors who have erred, this does not mean that preventative work rules cannot attain the desired result of minimizing malpractice claims. *See* Fla. Op. Atty. Gen. 078-25 (county hospital may require staff physicians to comply with rule "bearing a reasonable relationship to the hospital's operation purpose and to its . . . responsibility to its patients and their care and well-being"). Florida law requires hospitals to have "risk management" programs to control both staff and independent contractor physicians. Fla. Stat. §768.41 and §95.065.

There is therefore ample reason to believe that hospitals can identify and control the occurrence of incidents in hospitals which ultimately result in malpractice claims. Even if there were a legitimate conflict of opinion on such factual matters, the courts are obliged to uphold the statute against a constitutional challenge. It is in the power of hospitals to optimize expenditures on prevention of medical malpractice. This circumstance alone is enough to validate the statute on the points at issue.

E. It Was Rational For the Legislature To Believe That Hospitals Were Liable Under State Law For Many Malpractice Claims Brought Against Physicians.

The hospitals have made much of the argument that they are paying for claims brought against physicians. Because 80% of claims arise out of incidents in hospitals, there is only one reason why more claims are not against hospitals—plaintiffs have not joined hospitals as defendants. If the Fund were unavailable as a solvent means of payment, plaintiffs would more often join Hospitals in tort suits. The legislature was doubtless aware that many of the "claims" viewed in the Fund's records as attributable to physicians would be, in the eyes of the law, also attributable to hospitals.

Robert Atkins, the Hospitals' key witness below, admitted that the hospital emergency room is one of the most fertile sites of malpractice claims. The plaintiff in such a case will probably sue the physician, if he is financially responsible, but the hospital will also be liable as holding itself out to provide emergency care. *Irving v. Doctors Hospital of Lake Worth, Inc.*, 415 So.2d 55 (Fla. 4th DCA 1982) (especially page 57 n.2).

Even in the non-emergency room situation, whether a negligent physician is an agent of the hospital, making the latter vicariously liable for the torts of the former, is a jury matter. *Pinillos v. Cedars of Lebanon Hospital Corp.*, 403 So.2d 365, 368-69 (Fla. 1981); *Webb v. Priest*, 413 So.2d 43, 47 n.2 (Fla. 3d DCA 1982).

There was testimony below that the trend of Florida law was toward greater vicarious liability of hospitals

for physician negligence; and, of course, to the extent that hospitals have the right to control situations which cause malpractice claims, liability can be based directly on negligence rather than on the theory that the doctor is an agent of the hospital. It was rational for the legislature to have believed hospitals would be liable for many *physician* malpractice claims and therefore that it is fair to require hospitals to pay for them.

These reasons are all rational and plausible, and therefore the Hospitals' challenge to the cap on physician assessments cannot succeed.

III.

THE HOSPITALS RAISE NO DUE PROCESS ISSUE WARRANTING THIS COURT'S CONSIDERATION

As this Court held in *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1 (1976),

> legislative Acts adjusting the burdens and benefits of economic life come to the Court with a presumption of constitutionality, and . . . the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way.
>
> *Id.* at 15.

The analysis under the equal protection clause and due process clauses is therefore identical—if there is a plausible, rational, reason which could justify the Legislature's actions, the statute will be sustained under both clauses of the Fourteenth Amendment.

The *Turner* case, just-cited, shows that the cap on physician assessments is valid. In *Turner*, the legislature required that employers pay for the expenses of black lung disease suffered by their employees. In the instant case, the legislature has decreed that hospitals (who voluntarily join the Fund) pay in some circumstances for some malpractice claims attributable in the first instance to physicians. The holding of this Court in *Turner* is applicable to our situation: "It is enough to say that the Act approaches the problem of cost-spreading rationally; whether a broader cost-spreading scheme would have been wiser or more practical under the circumstances is not a question of constitutional dimension." *Id.* at 19. For the reasons discussed, *supra*, the Florida legislature approached the problem of spreading the costs of medical malpractice in a rational way.

The Hospitals attempt to distinguish *California State Automobile Ass'n Inter-Insurance Bureau v. Maloney*, 341 U.S. 105 (1951). The case is distinguishable from the instant case, but not for any of the reasons cited by the Hospitals. In *Maloney*, this Court approved a California statute which required all insurers doing business in the State to join together and insure "poor risks", with the cost to be equitably divided by the State Insurance Department. The constitutional issue in *Maloney* arose because the plan was a *mandatory* one, with the insurance companies *required* to participate on terms dictated by the State. In our case, on the other hand, the particular group of Hospitals who are now Appellants voluntarily joined the Fund and therefore accepted the terms of the legislature's invitation. The voluntary acceptance of the statute's terms makes their due process argument frivolous.

CONCLUSION

Essentially, the Hospitals are challenging a plainly rational economic regulation. The Hospitals were absolutely unsuccessful in raising their federal constitutional claims below, and this Court has denied the Hospitals' motion for stay of the mandate despite the Hospitals' uncontested assertion that

> If the stay is denied, the FPCF has declared that it will proceed to collect the more than $12 million in assessments from the hospitals that are parties to this appeal, and will immediately disburse *all* such funds to physician malpractice plaintiffs having claims against the Fund, whether through judgment or settlement. [citation omitted.] Because all amounts paid by Appellants will immediately be disbursed, there is no source from which they can be repaid.
>
> "Emergency Application for Stay" at 6.

Apparently this Court has concluded that the Hospitals' chances of prevailing are so remote that a stay was not justified, even though without it the Hospitals could not be given practical relief by an eventual victory in this Court.* Full briefing is not necessary, and Appellees' Motion to Dismiss For Want of A Substantial Federal

*This fact situation might be such that this appeal could be dismissed as moot. Because it is so clear that the Florida Supreme Court correctly decided the federal constitutional questions before it, appellees do not rely on this ground in urging this Court to terminate this groundless appeal.

Question or Motion to Summarily Affirm should be granted.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that three true and correct copies of the above and foregoing Alternative Motions to Dismiss Appeal or to Affirm Judgment Appealed and attached Appendix was mailed this 29th day of February, 1984 to the addressees listed on the attached Service List.

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